

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 7 0 4 9 9 9 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) HELEN BOWMAN				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 17 1987				2b. HOUR 10:29P M			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 4, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES MD.					
10. CITY OR TOWN OF DEATH LA PLATA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIANS MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY Retail			
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN LaPlata		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. Box 308 20646			
14. FATHER'S NAME FIRST MIDDLE LAST Bohme				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS William C Bowman Sameas #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/86 , 19____, to 2/17/87 , 19____, that (I) (we) lost saw the deceased alive on 2/17/87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.											
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/18/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T PACE, M.D.				22e. ADDRESS WALDORF, MARYLAND 20601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 20Feb1987		23c. NAME OF CEMETERY OR CREMATORY Washington National				23d. LOCATION CITY OR TOWN COUNTY STATE Cemetery Suitland PG M			
24. FUNERAL DIRECTOR NAME Robert E Wilhelm				ADDRESS Suitland, Md.		25a. DATE REC'D. BY REGISTRAR FEB 18 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

BP

[Faint, illegible handwriting covering the majority of the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 0 5 0 0 0					
1. DECEASED NAME (TYPE OR PRINT) Wade W. Broomfield				2a. DATE OF DEATH MONTH DAY YEAR February 24 1987				2b. HOUR 12:45A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct 5, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.			
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Drug Store	
13a. STATE Maryland 13b. COUNTY Charles 13c. CITY OR TOWN Lothian				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 188 Waysons Mobile Ct 20711			
14. FATHER'S NAME FIRST MIDDLE LAST Millard W Broomfield				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances E Cranfill					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-18-8136		17. INFORMANT ADDRESS Laura C Broomfield Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) COPD DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Congr aortic Dis (b) Semibloodine									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9-10, 1986 to 2-24, 1987 , that (I) (we) last saw the deceased alive on 2-24, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature] DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-24-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Howell, M.D.				22e. ADDRESS Pennbrooke Square, Waldorf, Md. 20601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 26Feb1987		23c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD			
24. FUNERAL DIRECTOR NAME Robert E Wilhelm ADDRESS Suitland, Md.				25a. DATE REC'D. BY REGISTRAR MAR 02 1987 25b. REGISTRAR'S SIGNATURE [Signature]					

044574 FEB 19 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05001
REG. NO.

FOR
1- STATE
REGISTRAR

3x3

6

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John O Butler

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 2 2 19 87 2b. HOUR 09:25 A M

3. SEX M 4. RACE B 5. DATE OF BIRTH MONTH DAY YEAR 06 09 06 80 6. AGE (IN YEARS) (LAST BIRTHDAY) 80 YRS. 7c. DATE PRONOUNCED DEAD 2 2 19 87 2d. HOUR 09:25 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Charles Co MD

10. CITY OR TOWN OF DEATH La Plata 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE MD 13b. CITY Charles 13c. CITY OR TOWN Fawnlener 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS 20632 Popes Creek Rd.

14. FATHER'S NAME FIRST MIDDLE LAST Benny Butler 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Proctor

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) unknown 16b. SOCIAL SECURITY NO. 214-18-8501 17. INFORMANT ADDRESS Charles Butler SAA

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDIOTIN GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE David N. Gingrich TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2/2/87

EXAMINER'S NAME (TYPE OR PRINT) DAVID N. Gingrich ADDRESS 5019 Woodhewen Dr. La Plata, MD

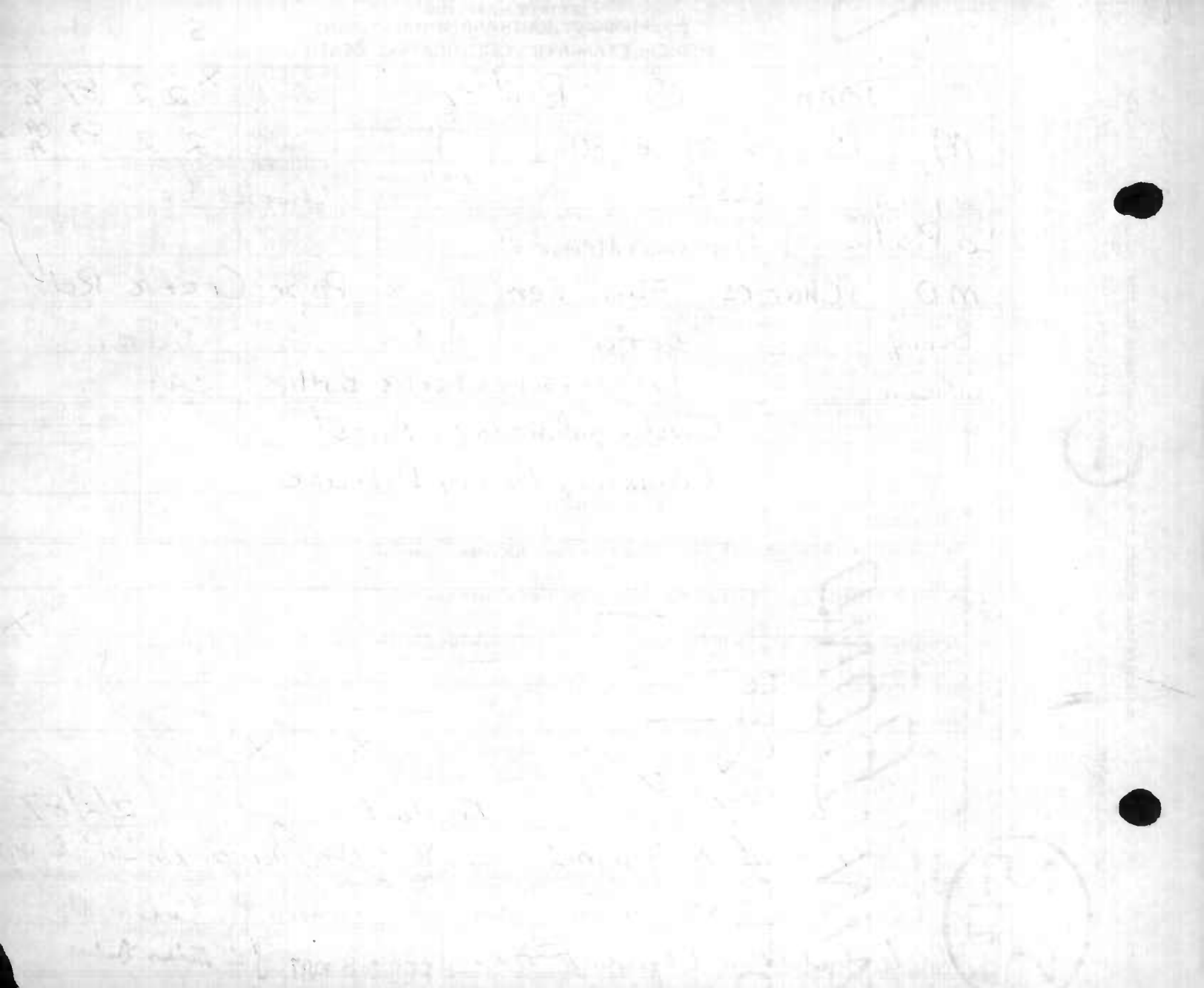
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 2-7-87 23c. NAME OF CEMETERY OR CREMATORY ST. IGNATIUS CATH CH. 23d. LOCATION CITY OR TOWN COUNTY STATE CHAPEL PT. CHAS. MD.

24. FUNERAL DIRECTOR NAME Martell Adams ADDRESS 25a. DATE REC'D. BY REGISTRAR FEB 18 1987 25b. REGISTRAR'S SIGNATURE J. Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82



043390 FEB - 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

05002

1. DECEASED NAME (TYPE OR PRINT) Raymond R. Cross			2a. DATE OF DEATH MONTH DAY YEAR February 1, 1987		2b. HOUR 12:37A
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR SEPT. 28, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH LAPLATA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHARLES CO. BOARD OF EDUCAT		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY CHARLES		
13c. CITY OR TOWN HUGHESVILLE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE RT 1, BOX 455 (20637)			13f. CITY OR TOWN ION		
14. FATHER'S NAME FIRST MIDDLE LAST JENNINGS C. CROSS SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA MAE CANTER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 218-30-2677		
17. INFORMANT Grace D. Cross			17. ADDRESS Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Massive cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Five days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertension, Diabetes mellitus					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-27 19 87 , to 2-1 19 87 , that (I) (we) lost saw the deceased alive on 1-31-87 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Seth		DEGREE M.D.		22c. DATE SIGNED 2-1-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Baljeet S. Sethi, M.D.		22e. ADDRESS Waldorf, Md. 20601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 4, 1987		23c. NAME OF CEMETERY OR CREMATORY All Faith Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Charlotte Hall St. Marys					
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley		ADDRESS Leonardtwn, Md.		25a. DATE REC'D. BY REGISTRAR FEB 6 1987	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		25c. REGISTRAR'S NAME Md.			

MEDICAL CERTIFICATION

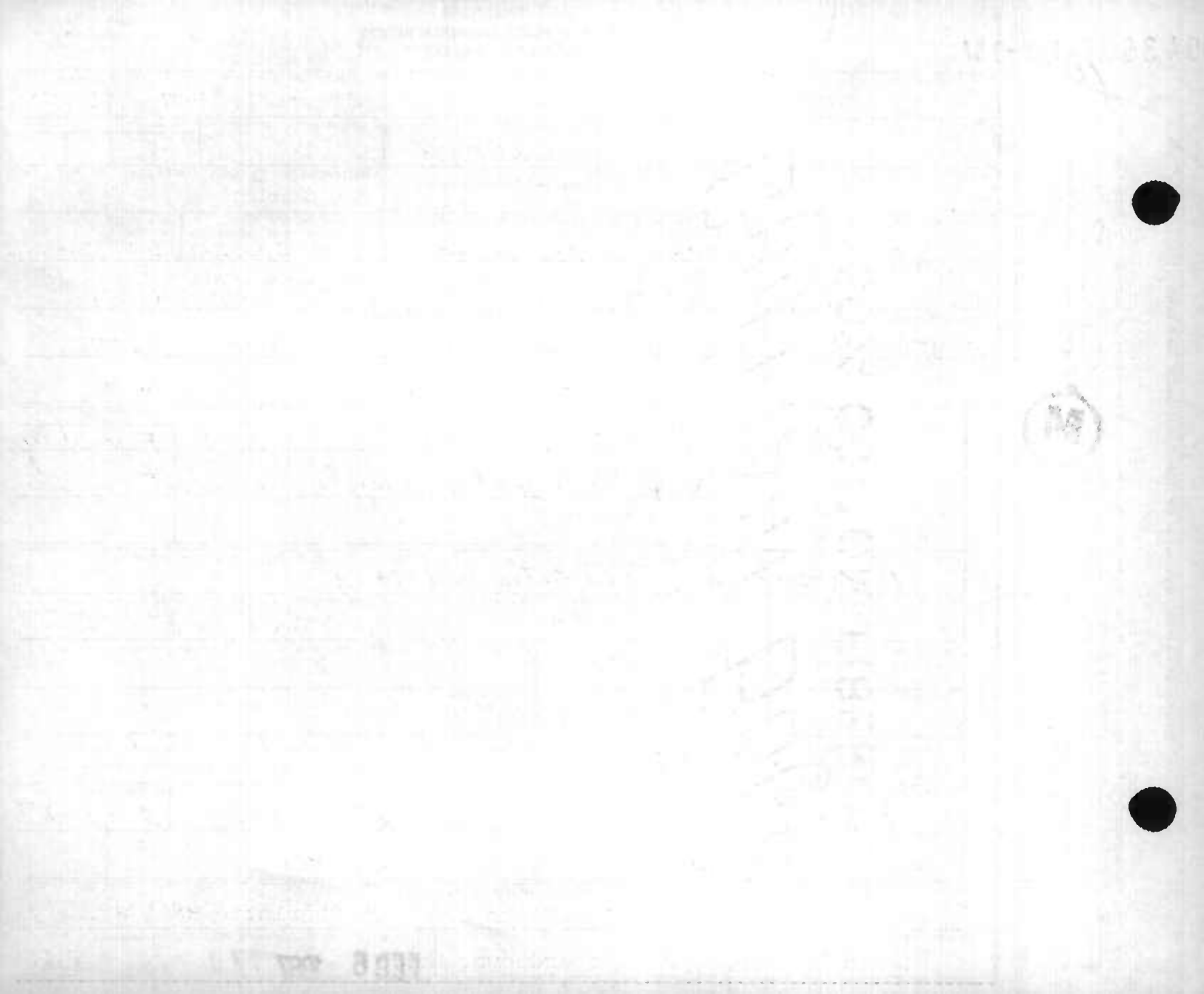
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMH - 16 60M 7/84
(VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial history paper. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene and for record, cremation, or removal.

IMPORTANT: If item 21 is marked as being a traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 05003	
1. DECEASED NAME (TYPE OR PRINT) James A Dorsey					2a. DATE OF DEATH MONTH DAY YEAR February 4, 1987			2b. HOUR a. 12:15 M			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR JULY 6, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.					
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED VETERAN		12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY CHARLES		13c. CITY OR TOWN HUGHESVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST RUBIN A. DORSEY					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLINA V. HICKS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1947		17. INFORMANT SHIRLEY DORSEY		ADDRESS MARBURY, MARYLAND 20658					
18. CAUSE OF DEATH (Enter only one cause per line fatal, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation and arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Vascular Disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes Mellitus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1986, 19 to 21, 1986, that (I) (we) lost saw the deceased alive on 1/23, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE George Wathen, M.D.				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/4/87			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE FEB. 9, 1987		23c. NAME OF CEMETERY OR CREMATORY MARYLAND VETERANS		23d. LOCATION CITY OR TOWN COUNTY STATE CHELTENHAM, PRINCE GEORGES, Md.			
24. FUNERAL DIRECTOR THORNTON'S FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					

PROX
COTTON
MOTOM
PIL

Transferred to [illegible]
all [illegible] [illegible]
[illegible] [illegible]



11/15/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from this form. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation.

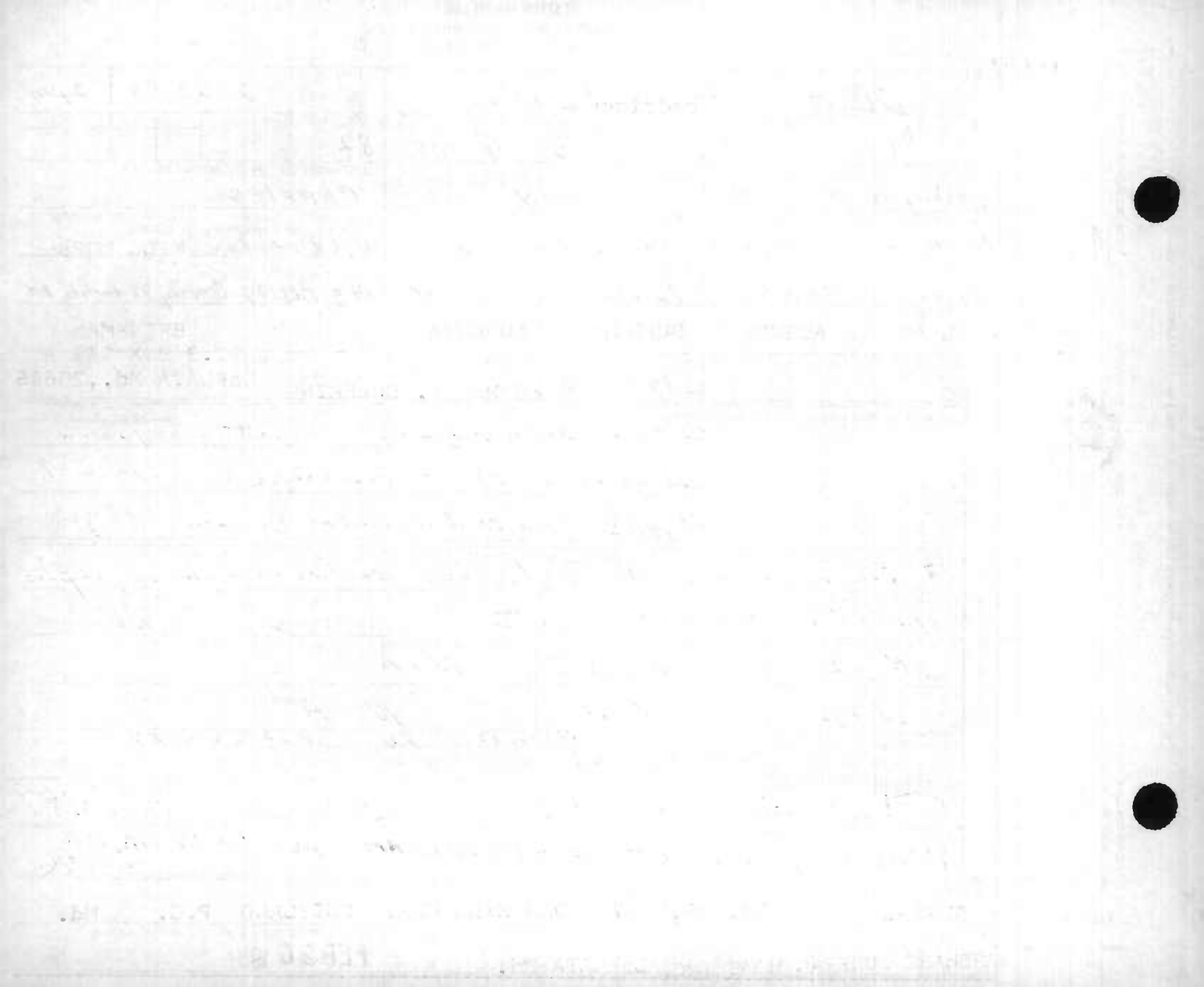
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Albert Frederick Duehring</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2 23 87</i>			2b. HOUR <i>2pm</i>				
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 9 05</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>82</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>CHARLES</i> MD.				
10. CITY OR TOWN OF DEATH <i>LA PLATA</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Charles County Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Woodworker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>MILL WORK</i>		
13a. STATE <i>Md.</i>					13b. COUNTY <i>Charles</i>		13c. CITY OR TOWN <i>La Plata</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME <i>CARL AUGUST DUEHRING</i>					15. MOTHER'S MAIDEN NAME <i>AUGUSTA BRINKMAN</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>					16b. SOCIAL SECURITY NO. <i>577-10-5148</i>		17. INFORMANT <i>NORMAN F. DUEHRING</i>			
18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertensive cardiovascular Disease</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 min</i> <i>1 month</i> <i>10 yrs</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Parkinson's Disease, Renal failure, cardiac arrhythmia, sepsis</i>										
19a. DATE OF OPERATION <i>1/25/87</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Recurrent decubitus ulcers</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>NIA</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>NIA</i>				
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) <i>NIA</i>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>NIA</i>				
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 12, 1986</i> to <i>Feb 23, 1987</i> , that (I) (we) last saw the deceased alive on <i>Feb 11, 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Paul E. Pritchett MD</i>						DEGREE <i>MD</i>		22c. DATE SIGNED <i>2/23/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PAUL E. PRITCHETT, MD</i>						22e. ADDRESS <i>118 LA GRANGE AVE. LA PLATA, MD 20646</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>FEB. 26, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CEM.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>SUITLAND P.G. Md.</i>			
24. FUNERAL DIRECTOR NAME <i>AREHART FUNERAL HOME INC. LaPLATA Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>FEB 26 1987</i>				
						25b. REGISTRAR'S SIGNATURE <i>Lia Gordon-Rodriguez</i>				



045338 FEB 25 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05005
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles RICHARD Elder			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 15 19 87			2b. HOUR M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 05/29/53	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS 33 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 15 19 87	7d. HOUR 6:47A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.		
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner-operator		12b. KIND OF BUSINESS OR INDUSTRY Liquor Store	
13a. STATE Maryland		13b. COUNTY Charles	13c. CITY OR TOWN Bel Alton		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Dove Drive , 20611	
14. FATHER'S NAME FIRST MIDDLE LAST Albert L. Elder, Jr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dolores Carr				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-60-6028		17. INFORMANT ADDRESS Star Rt. 5 Box 403 La Plata, Md				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a.		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		
ACTUAL SIGNATURE <i>Dennis F. Smyth</i> M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 2/15/87
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St. Balto. MD.		

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 02/18/87	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE La Plata, Charles, Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Arehart Funeral Home, Inc., La Plata, Md.		25a. DATE REC'D. BY REGISTRAR FEB 24 1987	25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 9, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER FORM. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 FOR OR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Barbara C. onnie Gehring			2a. DATE OF DEATH MONTH DAY YEAR 2-11-87		2b. HOUR 4:15 PM
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR 3-31-01	6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.		
10 CITY OR TOWN OF DEATH LaPlata, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Charles County Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Charles	13c. CITY OR TOWN Bryantown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rt. 232 /20617	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Hoffman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Moran		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 225-05-1884	17. INFORMANT 503 Charles Street Herman Gehring Hughesville, Md. 20637		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 min
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease		20 yrs
DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure		25 yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Peptic ulcer, organic brain syndrome, sepsis

19a. DATE OF OPERATION n/a	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED n/a	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDIC (EXAMINER)) n/a	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR n/a 19 87	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) n/a	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> n/a	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) n/a	21f. LOCATION STREET CITY OR TOWN COUNTY STATE n/a	

22a. I certify that (I) (this hospital) attended the deceased from **2/7** 19 **83** to **2/11** 19 **87** that (I) (we) last saw the deceased alive on **2/31** 19 **87**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Paul E. Pritchett MD	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2/11/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL E. PRITCHETT, MD		22e. ADDRESS 118 LA GRANGE AVE, LA PLATA, MD 20646	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-14-87	23c. NAME OF CEMETERY OR CREMATORY St. Mary's	23d. LOCATION CITY OR TOWN COUNTY STATE Bryantown Charles Md.
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24 FUNERAL DIRECTOR NAME Huntt Funeral Home	ADDRESS P. O. Box 156 Waldorf, Md. 20601	25a. DATE REC'D. BY REGISTRAR FEB 20 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove checkboxes. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2a DATE OF DEATH		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		9:30am	
Diann Reklis Good		February 3, 1987			
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	51 YRS	IF UNDER 24 HRS	
		Aug. 22, 1935			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Charles MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY		
Indian Head	23 Potomac Avenue	Housewife	Domestic		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Md.	Charles	Indian Head	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	23 Potomac Avenue 20640	
14 FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
Peter John Reklis			Julia Bolger		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
No		217-34-1471	23 Potomac Avenue Robert B. Good, Indian Hd., Md. 20640		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Large cell lung cancer with metastases to brain and liver</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. certify that (I) (this hospital) attended the deceased from <u>November 19 86</u> to <u>February 19 87</u> that (I) (we) last saw the deceased alive on <u>1-12</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>Kai-Yiueung</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Dr. Kai-Yiueung		8926 Woodyard Rd., Clinton, Md. 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	2-5-87	St. Charles Cem.		Glymont, Charles, Md.	
24 FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Huntt Funeral Home, Waldorf, Md. 20601		FEB 6 1987		Julia Swider-Pandora	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards 1 and 2 and file with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the official, it should be detached for use on the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Viola Grace Harrison					2a. DATE OF DEATH MONTH DAY YEAR 2/27/87		2b. HOUR 6:14 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 14 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.			
10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse	12b. KIND OF BUSINESS OR INDUSTRY ANN Mem. Hospital		
13a. STATE Maryland		13b. COUNTY Charles	13c. CITY OR TOWN Waldorf	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 338-A, Owens Rd, 20601		
14. FATHER'S NAME FIRST MIDDLE LAST Edward Walters			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Gibson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Daughter Billie Parker, Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Parkinson's Disease. Advanced age.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>2/26/87</u> , 19 <u>87</u> , to <u>2/27/87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/26/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Khadar Baig</i>			DEGREE		22c. DATE SIGNED 2/28/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Khadar Baig, M.D.			22e. ADDRESS La Plata Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-2-87	23c. NAME OF CEMETERY OR CREMATORY Belle Haven		23d. LOCATION CITY OR TOWN Belle Haven	STATE Va.		
24. FUNERAL DIRECTOR NAME Hunt Funeral Home,			ADDRESS P.O. Box 156 Waldorf, Md. 20601		25a. DATE REC'D. BY REGISTRAR MAR 03 1987		
			25b. REGISTRAR'S SIGNATURE <i>Michael Anderson</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return carbon copies, pages 1 and 2, and 7 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alice Robey Irwin			2a. DATE OF DEATH MONTH DAY YEAR February 14, 1987			2b. HOUR a 1:12 M			
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 10, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.			
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY at Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Bel Alton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. 301 and Irwin Road 20611	
14. FATHER'S NAME FIRST MIDDLE LAST Matthew Irwin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Robey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-56-0257		17. INFORMANT ADDRESS Louise Lyon Hruska, Box 95 Bel Alton, Md. 20611					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 min 10 yrs 20 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Pulmonary edema, congestive heart failure, kidney failure, hypertension									
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED n/a				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR n/a		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) n/a					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) n/a		21f. LOCATION STREET n/a		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/17 , 19 80 , to 2/14 , 19 87 , that (I) (we) last saw the deceased alive on 2/13 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Paul Pritchett M.D.				DEGREE				22c. DATE SIGNED 2/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Pritchett, M.D.				22e. ADDRESS La Plata, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/18/87		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery		23d. LOCATION (CITY OR TOWN) Chapel Point, Maryland			
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc.				ADDRESS La Plata, Md.		25a. DATE REC'D. BY REGISTRAR FEB 19 1987		25b. REGISTRAR'S SIGNATURE John Gordon-Rudick	

1981 9 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 05010	
1. DECEASED NAME (TYPE OR PRINT) Robert Everett Lee					2a. DATE OF DEATH MONTH DAY YEAR February 4 1987			2b. HOUR 6:20 P.M.			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 10, 1931		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.					
10. CITY OR TOWN OF DEATH LA PLATA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RT 225 La Plata, Maryland				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER			12b. KIND OF BUSINESS OR INDUSTRY PRIVATE		
13a. STATE MARYLAND		13b. COUNTY CHARLES		13c. CITY OR TOWN LA PLATA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RT. 225 / 20646			
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD LEE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VICTORIA BOND						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES UNKNOWN				16b. SOCIAL SECURITY NO. 215-26-2395		17. INFORMANT ADDRESS DOROTHY E. LEE -RT. 225 LA PLATA, Md. 20646					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medically caused by general weakness</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Weakness</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/27</u> , 19 <u>87</u> , to <u>2/4</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1/27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>[Signature]</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/4/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. W. [Signature]				22e. ADDRESS LA PLATA, Md. 20646							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE FEB. 9, 1987		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CH. CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE LA PLATA, CHARLES, Md.			
24. FUNERAL DIRECTOR NAME THORNTON'S FUNERAL HOME						ADDRESS POMONKEY, Md.		25a. DATE REC'D. BY REGISTRAR FEB 09 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

ON
FIELD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sol Levine			2a. DATE OF DEATH MONTH DAY YEAR February 9 1987			2b. HOUR 2:35p.				
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 25, 1925		6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.				
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION communications manager		12b. KIND OF BUSINESS OR INDUSTRY U.S. govt.		
13a. STATE Maryland			13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Harry Levine			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tillie Wexler			13e. STREET ADDRESS / ZIP CODE 1118 Hamlin Rd. 20601				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1958-1965		17. INFORMANT wife				ADDRESS same as 13 a-e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ① CHRONIC ATRIAL FIBRILLATION ② DIABETES MELLITUS										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2-9- 19 87 , to 2-9- 19 87 , that (I) (we) last saw the deceased alive on 2-9- 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE V. Anmangandla					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2-9-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vidyasagar Anmangandla M.D.					22e. ADDRESS P.O. Box 282 Charlotte Hall, Md. 20632					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 13, 1987		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Arlington, VA			
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.					25a. DATE REC'D. BY REGISTRAR 35 FEB 13 1987		25b. REGISTRAR'S SIGNATURE <i>John F. ...</i>			
24. OLD Alexander Ferry Rd., Clinton, MD 20735										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and hold them for filing within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition.

IMPORTANT: If item 21 is marked as (a) or (b), it shows any injury, or other traumatic cause of death, and should be filled in as such.

BP _____



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

05012

1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Lula		MIDDLE L		LAST Lewis		2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH 2		DAY 28		YEAR 1987		2b. HOUR 9:48							
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH 5		DAY 29		YEAR 22		6. AGE (IN YEARS) (LAST BIRTHDAY) 64 YRS.		IF UNDER 24 YRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH 2		DAY 28		YEAR 1987		2d. HOUR 9:48			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES																	
10. CITY OR TOWN OF DEATH LA PLATA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIANS MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY PRIVATE																	
USUAL RESIDENCE (IF IN RESIDENCE HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE MARYLAND		13b. COUNTY CHARLES		13c. CITY OR TOWN MARBURY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. BOX 326/20658															
14. FATHER'S NAME FIRST JOHN						MIDDLE RIDDICK						15. MOTHER'S MAIDEN NAME FIRST MATTIE						MIDDLE REYNOLDS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS GEORGE LEWIS-P.O. BOX 326 MARBURY, Md. 20658																			
NO		N/A		229-30-1697																			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years	
Cardiac Arrest		ASCVD	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE H M Haft		TITLE (SPECIFY) M.D. Charles C		MEDICAL EXAMINER		DATE SIGNED 2/28/87	
EXAMINER'S NAME (TYPE OR PRINT) H M Haft MD		ADDRESS 1020 Darley Drive LaPlata MD 20646					

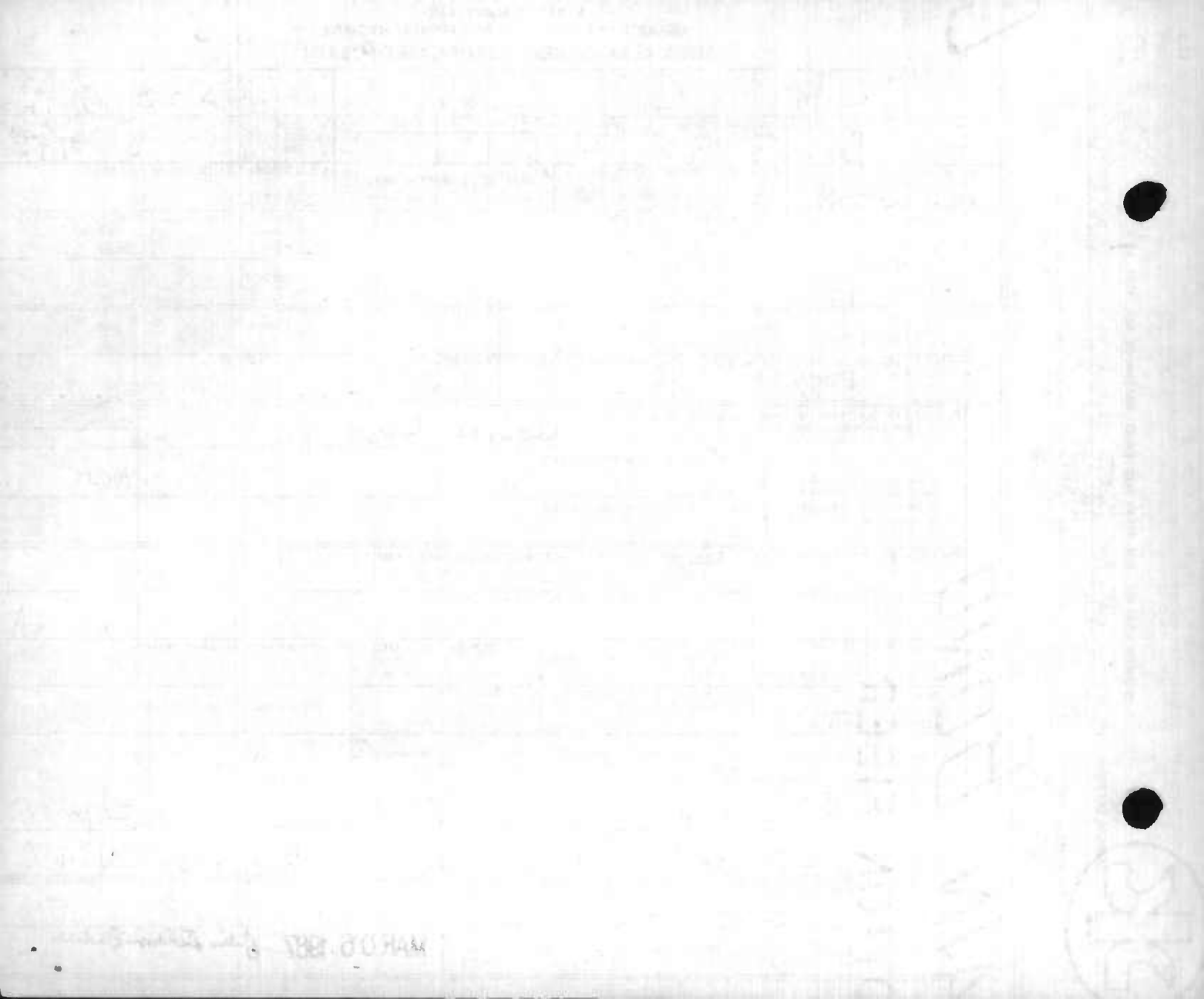
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-5-87		23c. NAME OF CEMETERY OR CREMATORY MT. HOPE CHURCH CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE IRONSIDES, CHARLES, MARYLAND	
24. FUNERAL DIRECTOR NAME THORNTON'S FUNERAL HOME				ADDRESS POMONKEY, MARYLAND		25. DATE RECEIVED BY REGISTRAR MAR 06 1987	
				REGISTRAR SIGNATURE Julia Johnson-Radner			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the following pages. Pages 1 through 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 15 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM M. MORAN			2a. DATE OF DEATH MONTH DAY YEAR 02/23/87		2b. HOUR 10:55 P.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 06/23/00		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DUBOIS, Md.	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles Co. MD.	
10. CITY OR TOWN OF DEATH LA PLATA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Charles County Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	12b. KIND OF BUSINESS OR INDUSTRY FARMING	
13a. STATE Md.			13b. COUNTY Charles	13c. CITY OR TOWN Hughesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE WASHINGTON MORAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE WILLIAMS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 213-22-0583		17. INFORMANT HELEN THERESA HALL ADDRESS BOX 42 CHAPTICO, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIAC DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE LUNG DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) URINARY TRACT INFECTION, URINARY RETENTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/24/84 19 to 2/23/87 19, that (I) (we) last saw the deceased alive on 2/3/87 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, after (he) (she) (it) died.					
22b. SIGNATURE DR. MISHRA MD				22c. DATE SIGNED 2/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/26/87		23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE BRYANTOWN CHARLES MD.		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE MAR 02 1987 Julia Dindon-Rodman			
24. FUNERAL DIRECTOR NAME ADDRESS W. CLARKE MATTINGLEY, LEONARDTOWN, MD.					

BP

[Faint, illegible vertical text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) MARY LOUISE MUSCHETTE				2a DATE OF DEATH MONTH DAY YEAR February 21, 1987		
3 SEX FEMALE				2b HOUR 2:00 M.		
4 RACE BLACK		5 DATE OF BIRTH MONTH DAY YEAR MARCH 15 1896		6 AGE (IN YEARS LAST BIRTHDAY) 90		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) CHARLES		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH LaPLATA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RT. 3 BOX 120 OAK AVE. 20646		9 BALTIMORE CITY OR COUNTY OF DEATH CHARLES MD.		
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a STATE MARYLAND		12b COUNTY CHARLES		12c CITY OR TOWN LaPLATA		
13a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13b STREET ADDRESS OAK AVE.		13c ZIP, 20646		
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM THOMAS		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHARLOTTE GARNER		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO		
16b SOCIAL SECURITY NO. 219-16-0700		17 INFORMANT CHARLOTTE WINTERS		ADDRESS RT. 3 BOX 120 LaPLATA, Md. 20646		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac myopathy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Longstanding heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac arrhythmia</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>2-4-87</u> , 19 <u>87</u> , to <u>2-12-87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2-12-87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <u>Ignacio T. Garcia, M.D.</u>				22c DATE SIGNED		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>IGNACIO T. GARCIA</u>				22e ADDRESS <u>BOX K, LA PLATA, MD</u>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 2/25/87		23c NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		
23d LOCATION CITY OR TOWN COUNTY STATE LaPLATA CHARLES Md.		24 FUNERAL DIRECTOR NAME ADDRESS AREHART FUNERAL HOME INC. 211 St. MARYS AVE.				
25a DATE OF REGISTRATION FEB 26 1987				25b REGISTRAR'S SIGNATURE <u>Julia Benson-Randall</u>		

2:00 P.M.

February 21, 1937

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove and attach to pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 13 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME FIRST MIDDLE LAST Dorothy May Norris						2a. DATE OF DEATH MONTH DAY YEAR Feb 12 1987	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 - 10 - 1999		2b. HOUR 3:30 A.M.	
6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.		10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER	
12b. KIND OF BUSINESS OR INDUSTRY AT HOME		13a. STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN LaPlata	
14. FATHER'S NAME FIRST MIDDLE LAST John P. Burdette		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Jones		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N/A	
17. INFORMANT ADDRESS Emma Clements RT 2 Box 2098 LaPlata Md.		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Cancer of Colon DUE TO, OR AS A CONSEQUENCE OF (b) Distended Gallbladder DUE TO, OR AS A CONSEQUENCE OF (c) Advanced Atherosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 2/1/87 to 2/12/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE G. D. WATKINSON		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS LaPlata, Md. 20646					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 02/14/87		23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH'S CATH.		23d. LOCATION CITY OR TOWN COUNTY STATE POMFRET CHARLES MD.	
24. FUNERAL DIRECTOR NAME AREHART FUNERAL HOME, INC., LA PLATA, MD.		ADDRESS		25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE FEB 17 1987	

21140

1951



Handwritten notes and markings, including a large 'X' and various illegible scribbles.

Extremely faint and illegible handwritten text covering the majority of the page. Some fragments are visible, such as 'FROM SA...', 'TO...', and 'RE...', but the rest is too light to transcribe accurately.

046478

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove 26-Burial-transit permit and 27-Death certificate and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harry Lawrence Prather			2a. DATE OF DEATH MONTH DAY YEAR February 27 1987			2b. HOUR 2:49A _M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 15, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.			
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Projectionist		12b. KIND OF BUSINESS OR INDUSTRY Motion Pictures	
13a. STATE Maryland			13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST allen l. prather			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilla Ferguson			16. ADDRESS 203 West Dale Drive			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-03-6357		17. INFORMANT Don Prather-Son Waldorf, Md. 20601					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>COPD, long abuse</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4</u> , 19 <u>83</u> , to <u>2-27</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2-27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Daniel Howell</u>				22c. DATE SIGNED 2-27-87				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Howell, M.D.	
22e. ADDRESS Waldorf, Maryland 20601				22f. ADDRESS Waldorf, Maryland 20601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 03/03/87		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, P.G. Co., Md.			
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc.				ADDRESS La Plata, Md.		25a. DATE REC'D. BY REGISTRAR MAR 05 1987		25b. REGISTRAR'S SIGNATURE <u>Juan Anderson</u>	

07474

Handwritten notes and diagrams, including a large sketch of a person's head and shoulders in the upper left. The text is mostly illegible due to fading and bleed-through from the reverse side of the page. Some legible fragments include "March 1950", "March 1951", and "March 1952".

Handwritten notes at the bottom of the page, including the date "MAR 05 1950" and other illegible text.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or coroner should be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NELLIE LEMAIN RANDALL			7a. DATE OF DEATH MONTH DAY YEAR 2 18 1987		7b. HOUR P 5:50 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 8 1908		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? US		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS 78		
10. CITY OR TOWN OF DEATH LA PLATA, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIANS MEMORIAL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teletypist		12b. KIND OF BUSINESS OR INDUSTRY Metro. Police				
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. 925S, Box 342D/20601				
14. FATHER'S NAME FIRST MIDDLE LAST Richard H Teepie		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unavailable				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 579-10-7291		17. INFORMANT ADDRESS Kenneth W. Randall 900 Copley Avenue Waldorf, Md. 20601		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Drowning DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Renal Failure						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		70a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from 1986 , 19 2/18 , to 2/18 , 19 87 , that (1) (we) last saw the deceased alive on 2/18 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.						
22b. SIGNATURE G. L. WATKIN		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/18/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. L. WATKIN		22e. ADDRESS LA PLATA, Md 20646				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-23-87		23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial		
23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf Charles Md.		23e. DATE REC'D. BY REGISTRAR FEB 20 1987		23f. REGISTRAR'S SIGNATURE Julia Davidson-Rodner		
24. FUNERAL DIRECTOR NAME ADDRESS Huntt Funeral Home P. O. Box 156 Waldorf, Md. 20601		25. DATE REC'D. BY REGISTRAR FEB 20 1987				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

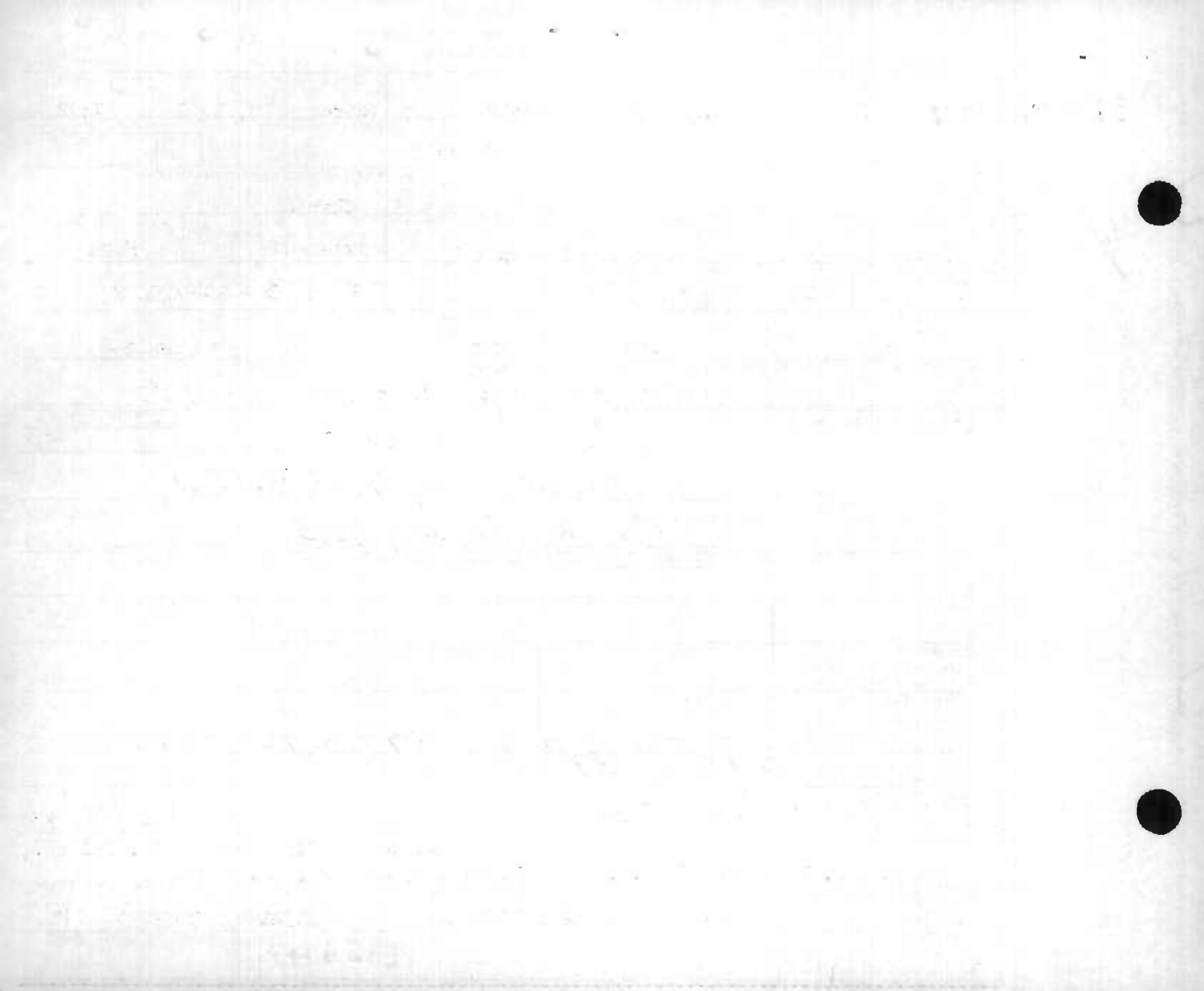
REG. NO.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emma Angeline Scott			2a. DATE OF DEATH MONTH DAY YEAR February 19, 1987		2b. HOUR 7:52 AM
3. SEX Female	4. RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR June 13 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland	13b. COUNTY Charles	13c. CITY OR TOWN Nanjemoy	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rt. 1, Box 66-F/20662	
14. FATHER'S NAME FIRST MIDDLE LAST Lazarus P. Dodd		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary F. Bowie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no --		16b. SOCIAL SECURITY NO. 218-14-3340		17. INFORMANT ADDRESS Frances M. Hathaway same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gas Asphyxiation - Pulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Heart Failure, Valvular Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic obstructive Lung Disease</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>2-18-87</i> , 19 <i>87</i> , to <i>2-19</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>2-18</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Michael A. Leatherwood, M.D.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2/19/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Leatherwood, M.D.		22e. ADDRESS Waldorf Medical Park, Rt. 301 So., Box 8 & 9, Waldorf, Md. 20601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-23-87	23c. NAME OF CEMETERY OR CREMATORY TRINITY MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE WALDORF BY CHARLES. Md.	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home		P. O. Box 156 Waldorf, Md. 20601		25a. DATE REC'D. BY REGISTRAR <i>FEB 24 1987</i>	
BP		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph Edward Simms			2a. DATE OF DEATH MONTH DAY YEAR 2/28/87			2b. HOUR 1:00a M			
3. SEX J Male		4. RACE Black		5. DATE OF BIRTH 08/31/1922 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 64		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.			
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians memorial hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Ret. Self Employed	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Port Tobacco		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. 6, Box 1143, 20677	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Smith Simms				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aline G. King					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 216-22-1574		17. INFORMANT ADDRESS Rt. 6, Port Tobacco Md. Margaret Marie Williams, Sister			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of Bladder DUE TO, OR AS A CONSEQUENCE OF (c) ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. 3 1/2 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 2-26-87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bladder Cancer			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4-1, 1983 , to 2-27, 1987 , that (I) (we) last saw the deceased alive on 2-27, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (and) not view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Howell, M.D.				22c. DATE SIGNED 2-28-87				22d. ADDRESS La Plata M.D.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 03/06/87		23c. NAME OF CEMETERY OR CREMATORY St. Catherins Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE McConchie, Charles, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Arenhart Funeral Home, Inc., La Plata, Md.						25a. DATE REC'D. BY REGISTRAR MAR 03 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please make certain papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

045258 FEB 20 1987

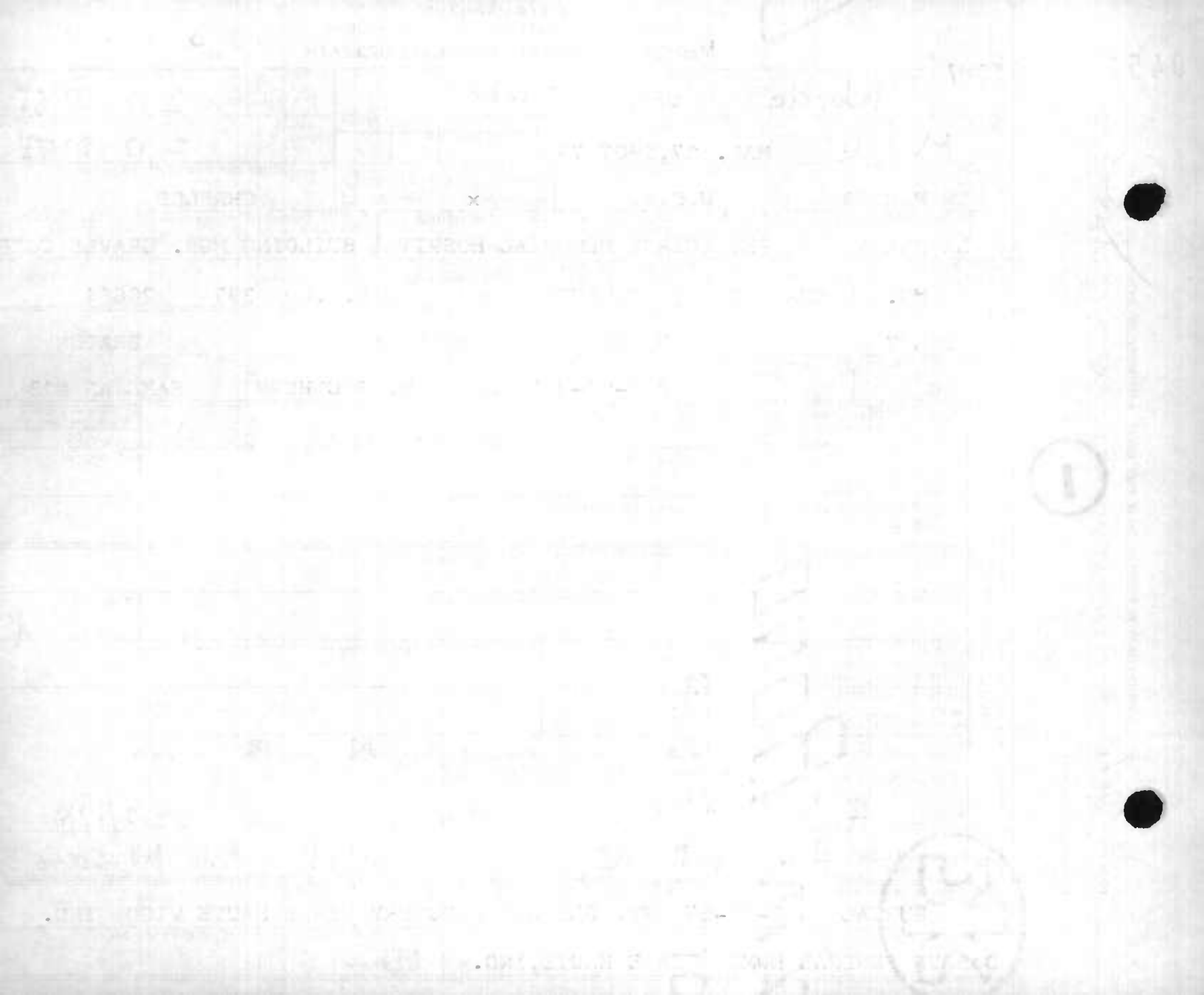
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										05020 REG. NO.	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nockie Quay Stucker										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 17 1987	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR MAR. 17, 1907		6. AGE (IN YEARS) LAST BIRTHDAY 79RS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 17 1987		7b. HOUR 6 ⁰⁰ M 7 ⁴¹ M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW MEXICO				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES MD.	
10. CITY OR TOWN OF DEATH LA PLATA				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIANS MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUILDING MGR.		12b. KIND OF BUSINESS OR INDUSTRY GRAVES CORP	
13a. STATE MD.										13b. CITY OR TOWN CHARLES	
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13d. STREET ADDRESS P.O. BOX 397 20664	
14. FATHER'S NAME FIRST MIDDLE LAST ESLEY STUCKER										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERNICE BRATEN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 305-01-0870				17. INFORMANT ADDRESS JOYCE M. SOUTHERN SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE H. M. Haft MD				TITLE (SPECIFY) M.D. Charles G.				MEDICAL EXAMINER DATE SIGNED 2/17/87			
EXAMINER'S NAME (TYPE OR PRINT) H. M. Haft MD				ADDRESS 1020 Darby Pl. LaPlata Md 20646							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 2-20-87		23c. NAME OF CEMETERY OR CREMATORY MT. PLESANT CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE TERRE HAUTE VIGO IND.	
24. FUNERAL DIRECTOR NAME DeBAUN FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR FEB 24 1987		25b. REGISTRAR'S SIGNATURE			



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07.84
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF THE DEATH. IF ANY DELAY IS NECESSARY, PLEASE
IN PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11. IF THE DEATH IS NOT INVESTIGATED, RETURN THE
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE DEATH CERTIFICATE. IF THE DEATH IS INVESTIGATED,
TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 M. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP_____

DHMH - 17

(VR AT5 ME (5))

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				05021 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
KATHERINE		R.		WOOLLS				2c. DATE ESTI-MATED		2d. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. DATE PRONOUNCED DEAD		7. TIME	
Female		Caucasian		12-19-86		19		2-6-87		7:04A	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED		11. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		US		WIDOWED		Charles county					
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		14. USUAL OCCUPATION		15. KIND OF BUSINESS OR INDUSTRY					
LaPlata		Physicians Memorail Hospital		FOR MOST OF WORKING LIFE							
16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		17. STATE		18. CITY OR TOWN		19. INSIDE CITY LIMITS?		20. STREET ADDRESS			
Maryland		Charles		Welcome		YES NO		Rt 6, Box 165/Welcome, MD			
21. FATHER'S NAME		22. MOTHER'S MAIDEN NAME		23. FIRST		24. FIRST		25. FIRST		26. FIRST	
Richard		Melinda		M.		K.		Young			
27. WAS DECEASED EVER IN U.S. ARMED FORCES?		28. SOCIAL SECURITY NO.		29. INFORMANT		30. ADDRESS					
NO											
31. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		32. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Sudden infant death syndrome											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
33. DATE OF OPERATION		34. CONDITION FOR WHICH OPERATION WAS PERFORMED?		35. AUTOPSY?							
				YES NO							
36. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		37. TIME OF INJURY		38. HOW INJURY OCCURRED							
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION							
NOT WHILE AT WORK		(AT HOME, STREET, FACTORY, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy		Inspection		Inquiry		and in my opinion death resulted from:					
Natural causes		Accident		Suicide		Homicide		Undetermined manner			
Margarita A. Korell		M.D.		Assistant		MEDICAL EXAMINER		DATE SIGNED		2-7-87	
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.		ADDRESS		111 Penn Street					
39. BURIAL, CREMATION, REMOVAL (SPECIFY)		40. DATE		41. NAME OF CEMETERY OR CREMATORY		42. LOCATION		COUNTY		STATE	
Burial		2-10-87		Trinity Memorial Gardens		Waldorf		Charles		Maryland	
43. FUNERAL DIRECTOR NAME		44. ADDRESS		45. DATE REC'D BY REGISTRAR		46. REGISTRAR'S SIGNATURE					
Huntt Funeral Home,		P.O. Box 156		Waldorf, Md. 20601		FEB 11 1987					



UNITED STATES

POST OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 60M 7/84
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 05022			
1. DECEASED NAME (TYPE OR PRINT) ETHEL				FIRST ETHEL MIDDLE JOSEPHINE LAST WRIGGLESWORTH				2. DATE OF DEATH MONTH Feb DAY 3 YEAR 1987 2b HOUR 10 MIN 04			
3. SEX F FEMALE		4. RACE C WHITE		5. DATE OF BIRTH MONTH MAY DAY 13 YEAR 1894		6. AGE (IN YEARS LAST BIRTHDAY) 92		7. IF UNDER 1 YEAR MONTHS YRS DAYS MIN.		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.					
10. CITY OR TOWN OF DEATH LA PLATA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Charles County Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK TYPIST		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT			
13a. STATE Md.				13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST ANDREW MIDDLE J LAST JONES				15. MOTHER'S MAIDEN NAME FIRST JACKIE MIDDLE J LAST HOLMES				13e. STREET ADDRESS / ZIP CODE 4909 Harwich Way, Waldorf, Md. 20601			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 579-60-1085		17. INFORMANT Daughter		ADDRESS 3808 Brewster Circle Betty Hughes, Waldorf, Maryland 20601			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest										15 min	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										10 yrs	
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac arrhythmia										10 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure										10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerotic Heart Disease, Rheumatoid arthritis											
19a. DATE OF OPERATION none				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED none				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:10 P.M. 2/3/87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) SLA					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) SLA		21f. LOCATION STREET SLA CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/31 , 19 87 , to 2/3 , 19 87 , that (I) (we) last saw the deceased alive on 1/31 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Paul E. Pritchett MD DEGREE						22c. DATE SIGNED 2/3/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL E. PRITCHETT, MD						22e. ADDRESS P.O. Box 1317, LA PLATA, MD. 20646					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 2/6/1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN Suitland COUNTY P.G. STATE Maryland			
24. FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf, Md. 20601 ADDRESS						25a. DATE OF REGISTRATION FEB 09 1987		25b. REGISTRAR'S SIGNATURE Julia Jackson-Randall			

FEB 08 1981

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

05023

FOR
1- STATE
REGISTRAR

1. DECEASED NAME

(TYPE OR PRINT)

987

FIRST

James

MIDDLE

G.

LAST

Young

2a. DATE KNOWN
OF DEATH ESTI-
MATED

MONTH

24

DAY

19

YEAR

87

2b. HOUR

11:45

AM

3 SEX

M

4. RACE

B

5. DATE OF BIRTH

5 28 38

6. AGE (IN YEARS)

48 YRS.

IF UNDER 1 YR.

MONTHS DAYS HOURS

IF UNDER 24 HRS.

MONTHS DAYS HOURS

2c. DATE
PRONOUNCED
DEAD

MONTH

24

DAY

19

YEAR

87

2d. HOUR

11:45

AM

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

UNITED STATES

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

CHARLES

MD.

10. CITY OR TOWN OF DEATH

LA PLATA

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

PHYSICIAN MEMORIAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

TRACTOR TRAILER DRIVER PRIVATE

12b. KIND OF BUSINESS
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

CHARLES

13c. CITY OR TOWN

INDIAN HEAD

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

68 MATTINGLY AVE./ 20640

14. FATHER'S NAME

CLYDE

MIDDLE

LAST

YOUNG

15. MOTHER'S MAIDEN NAME

MARY

MIDDLE

F.

LAST

TOYE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

YES

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

214-32-9577

17. INFORMANT

Sylvia A. Young

ADDRESS

4417 3rd Street, S.E.
Washington, D.C. 2003218. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy ☐Inspection ☒Inquiry ☒

and in my opinion

death resulted from: Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL
SIGNATURE

H.M. Hoff

TITLE (SPECIFY)

M.D. Charles Co. MEDICAL EXAMINER

DATE
SIGNED

2/5/87

EXAMINER'S NAME
(TYPE OR PRINT)

H.M. Hoff MD

ADDRESS

1020 Darley Dr. La Plata, Md

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

BURIAL

23b. DATE

2-10-87

23c. NAME OF CEMETERY OR CREMATORY

ST. CHARLES CEMETERY

23d. LOCATION
CITY OR TOWN

GLYMONT

COUNTY

CHARLES MD.

24. FUNERAL DIRECTOR

NAME

THORNTON FUNERAL HOME

ADDRESS

POMONKEY, MD.

25a. DATE REC'D. BY REGISTRAR

FEB 13 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT WITH FORM PM 3. AND 2 SHOULD BE KEPT WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 FOR OR TO BURIAL, CREMATION, OR REMOVAL.

WILLIAM H. HARRIS, JR.
1000 N. 10TH ST. APT. 101
DENVER, CO. 80202

TO: WILLIAM H. HARRIS, JR.
1000 N. 10TH ST. APT. 101
DENVER, CO. 80202

FROM: [illegible]
SUBJECT: [illegible]
[The body of the letter contains several paragraphs of extremely faint, illegible text.]

FEB 13 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST		MONTH DAY YEAR				HOURS MIN.			
MARGARET JANE YOUNG		2 2 87				6:45 P M			
3 SEX	4. RACE	5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE	WHITE	MONTH DAY YEAR		86 YRS		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
CANADA		U.S.				CHARLES COUNTY MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
LA PLATA		NURSING CENTER- MERIDIAN		HOME MAKER		AT HOME			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE	
Md.		ST. MARY'S		LEXINGTON PK.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		XXXX 4 MAJESTIC COURT, 20653	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		17 INFORMANT ADDRESS					
FIRST MIDDLE LAST		FIRST MIDDLE LAST		4 MAJESTIC COURT					
FREDRICK SMITH		MARGARET SMITH		WILLIAM F. YOUNG, LEXINGTON PRK., MD.					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
NA		163-20-7020		WILLIAM F. YOUNG, LEXINGTON PRK., MD.					
18. CAUSE OF DEATH: Enter only one cause per item for (a), (b), and (c).									
PART 1: DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Thyroid Cancer</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Cancer</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>4/27/87</u> to <u>2/2</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>4/27/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) and I did not view the body after death.									
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED			
<u>William F. Young</u>		M.D.				<u>2/3/87</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
<u>William F. Young</u>		<u>4010 N. W. 20640</u>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		02/06/87		MEMORIAL PARK		BETHLEHEM LEHIGH PA.			
24 FUNERAL DIRECTOR NAME		24b ADDRESS		24c DATE REC'D. BY REGISTRAR		25 REGISTRAR'S SIGNATURE			
AREHART FUNERAL HOME, INC. LAPLATA, MD		WALLACE M. LONG FUNERAL HOME, BETHLEHEM,		FEB 6 - 1987		<u>Julia Davidson-Randall</u>			

BP

CHIEF IN WARD

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